IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

August 20, 2008

Susan Broetje
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, Idaho 83687

Provider #13G001

Dear Ms. Broetje:

On **August 12, 2008**, a Complaint Survey was conducted at Idaho State School And Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003685

Allegation #1: Staff do not know the programs of the individuals they are assigned to work with at the day program.

Findings: An unannounced on-site complaint investigation was conducted on 8/4/08 - 8/12/08. During that time, observations, record reviews, and interviews with facility staff were completed with the following results:

Ten individuals were selected for review. Observations were conducted at the on-campus day programs throughout the survey. Individuals were noted to participate in the activities at the day programs and staff were observed to interact appropriately with them. Staff working with individuals at the day programs were interviewed and stated they had received training on programs for individuals. Staff were noted to have individuals' program book with them at the day program. Staff also stated if they did not know an individual's program, a staff from the building the individual lived on was in the group and able to answer questions or work with the individual. Individuals' programs were reviewed and compared to answers received during interviews and confirmed staff accurately reported individuals' programs.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Individuals' maladaptive behaviors are increasing and staff are not documenting all of the individuals' maladaptive behaviors.

Findings: An unannounced on-site complaint investigation was conducted on 8/4/08 - 8/12/08. During that time, record reviews and interviews with facility staff were completed with the following results:

Ten individuals were selected for review. Behavioral data and Behavior Reporting Forms were reviewed from 5/1/08 - 8/8/08 and did not indicate an overall increase in individuals' maladaptive behaviors. In addition, supervisory and direct care staff interviewed stated data was taken on both targeted and non-targeted behaviors. Clinicians interviewed stated there had not been an increase in behaviors.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The individuals' rooms are kept in an unsanitary manner.

Findings: An unannounced on-site complaint investigation was conducted on 8/4/08 - 8/12/08. During that time, observations and interviews with facility staff were completed with the following results:

Environmental surveys of individuals' rooms were conducted on 8/06/08 and 8/7/08. Individuals' rooms were noted to be cluttered with clothes and toys on the floor. There were no odors noted on the unit or in individuals' rooms. Staff were interviewed during the observations and reported individuals' were ask to clean their rooms on a daily basis, but would sometimes refuse. Staff stated if an individual continued to refuse to clean their room, staff would clean the room. During the environmental survey on 8/6/08 a housekeeper was present and stated individuals rooms were cleaned on a weekly basis.

The Qualified Mental Retardation Professional of the unit where the floor was noted to be cluttered was interviewed and stated individuals were to clean their rooms on a daily basis. If an individual refused, staff were to clean the room, if an odor was noted in a room, housekeeping would be called to clean the room.

Although the rooms were noted to be cluttered they were not unsanitary.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: There are not enough staff provided to the individuals who refuse to participate in the day treatment program.

Findings: An unannounced on-site complaint investigation was conducted on 8/4/08 - 8/12/08. During that time, observations, record reviews and interviews with facility staff were completed with the following results:

Interviews with supervisors, Qualified Mental Retardation Professionals and direct care staff were conducted throughout the survey. All staff reported if an individual refused to attend, or came back early from, the day program there would be sufficient staff on the unit with the individual. Additionally, staff reported that if there was a problem, they had the Red Alert system as a back up. Observations throughout the survey noted sufficient staff were on the living unit with individuals who were scheduled to be at the day program.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Individuals are being subjected to ongoing verbal, psychological, and physical abuse from other individuals.

Findings: An unannounced on-site complaint investigation was conducted on 8/4/08 - 8/12/08. During that time, observations, record reviews, and interviews with facility staff were completed with the following results:

Ten individuals were selected for review. Observations were conducted at the on-campus day programs and on the living units throughout the survey. Individuals were not noted to be subjected to verbal, psychological or physical abuse from other individuals. Staff were interviewed and stated if individuals were abusive to other individuals staff would separate them. If the Individual had a program regarding verbal or physical assaults, staff would follow the program. Staff stated any client to client assaults would be noted on the Behavior Reporting forms (BRF). Staff stated the BRFs were turned in daily for a professional staff to review.

Individuals were interviewed and stated one individual had behaviors that were frustrating but they did not feel threatened or intimidated by the individual. Clinicians and Qualified Mental Retardation Professionals were interviewed and stated they reviewed the BRFs regularly (daily or weekly) and had not noted an individual targeting other individuals. During an interview with a Clinician, it was reported that Clinicians were required to visit each class for the day program at least 2 times a week, if there was a pattern the Clinician would observe it or staff would report it.

Behavior Reporting Forms, grievances, Significant Event Reports, Investigations and Minor Event Forms from 5/1/08 - 8/8/08 were reviewed. The documents did include incidents of individuals being physically assaultive toward other individuals.

Patterns of individuals targeting another individual was not noted.

Therefore, the allegation was unsubstantiated due to a lack of sufficient evidence. However, the facility policy was not sufficient and a related deficiency at W149 was cited.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: The facility's abuse policy has changed and allegations of individual to individual abuse, neglect, and/or mistreatment are not being reported immediately to the Administrator and they are not investigated as they are handled only as a grievance.

Findings: An unannounced on-site complaint investigation was conducted on 8/4/08 - 08/12/08. During that time, record reviews and interviews with facility staff were completed with the following results:

Ten individuals were selected for review. Record review and interviews with facility staff were conducted throughout the survey. Qualified Mental Retardation Professionals (QMRP), Clinicians, Social Workers, the Administrator, and the Program Director were interviewed.

The facility's Abuse Prevention Policy, Significant Event Policy, Minor Incident Reporting Policy and Client Complaint and Grievance Policy were reviewed. The policies did not address incidents of verbal abuse, psychological abuse, or exploitation of an individual by other individuals residing at the facility.

During an interview on 8/8/08 from 2:00 - 3:05 p.m., the Administrator and the Program Director were asked about the facility's system for tracking individuals who were victims of verbal abuse. The Administrator stated there was no system in place to track individuals' victimization by other individuals for anything other than physical aggression. The Administrator stated the facility's QMRPs may have their own systems for tracking individuals' victimization by peers.

During an interview on 8/11/08 from 12:15 - 12:20 p.m., the staff responsible for compiling raw data was interviewed. When asked if the facility had any way of tracking individuals who were victims of verbal abuse, psychological abuse, or exploitation by peers from the data collected by the facility, the staff stated no current system was in place.

During interviews on 8/11/08 from 11:55 a.m. - 1:30 p.m. six QMRPs and three Clinicians were also interviewed. When asked if there was any way to track individuals who were victims of verbal abuse, psychological abuse, or exploitation by peers, the QMRPs and clinicians all stated there was not.

Additionally grievances from 5/1/08 - 8/4/08 for individuals were reviewed. One of the nine grievances reviewed was from an individual's guardian concerning the individuals safety. The facility failed to resolve the grievance filed by the Individual's guardian.

Therefore, the allegation was substantiated and deficient practice was identified at W149 for the facility failing to develop a policy regarding client to client verbal abuse, psychological abuse or exploitation. The facility was also cited at W125 for failure to allow and encourage individual rights including the right of individual's guardians to file complaints.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #7: Guardians are not being notified on the individuals' significant events per the guardians' requests.

Findings: An announced on-site complaint investigation was conducted on 8/4/08 - 8/12/08. During that time, record reviews and interviews with facility staff were completed with the following results:

Significant Event Reports, Minor Report Forms, and Investigations were reviewed. The Significant Event Reports and the Investigations documented guardians had been contacted or did not wish to be contacted. Additionally a random review of the facilities nursing notes documented guardian notification of Significant Events. The Minor Report Forms documented the report had been forwarded to the social worker to send to the guardian.

The Administrator was interviewed and stated the guardians were notified regarding the Significant Event Reports as soon as they were received. She stated the Minor Report Forms were sent to the social worker and the guardian received them weekly.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

SHERRI CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/mlw

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

August 20, 2008

Susan Broetje
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, Idaho 83687

Provider #13G001

Dear Ms. Broetje:

On **August 12, 2008**, a Complaint Survey was conducted at Idaho State School And Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003717

Allegation: Staffing ratios are not adequate.

Findings: An unannounced on-site complaint investigation was conducted on 8/4/08 - 8/12/08. During that time, observations, review of as-worked staffing schedules, and interviews with no less than 16 facility staff were completed with the following results:

Observations were conducted throughout the survey and staffing was noted to be adequate. The facility's as-worked staffing schedules, dated 5/08 - 7/08, were reviewed and documented staff were working the majority of the time with adequate staffing. Interviews were conducted throughout the survey with no less than 3 supervisory staff and 13 direct care staff. Supervisory staff reported there had been isolated incidents when there were lower numbers of staff on the units which made it difficult to monitor individuals and perform all duties, but they were able to meet the needs of the individuals. They also stated these low staffing ratios had been identified and changes were in process prior to 8/4/08. No less than 13 direct care staff stated if there was a behavioral incident with an individual and more staff were needed, they would use the Red Alert system to get help from another unit.

On 8/7/08, at 3:30 p.m., a Red Alert was observed in progress. A direct care staff was noted to immediately leave the unit who had called the Red Alert. When asked about the Red Alert the staff leaving stated he was not needed and was returning to his unit.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

SHERRI CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/mlw

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. BUTCH OTTER, GOVERNOR
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7007 0710 0002 7979 0338

October 6, 2008

Susan Broetje
Idaho State School and Hospital
1660 Eleventh Avenue North
Nampa, Idaho 83687

Re: Informal Dispute Resolution
Idaho State School and Hospital

Dear Ms. Broetje:

Attached are the results of the Informal Dispute Resolution process.

Enclosed you will find the amended survey report. Please resubmit the facility's Plan of Correction for the remaining deficiencies and return the 2567 to this office by **October 17, 2008**. This will become the facility's survey of record.

Should you have any questions or concerns, please do not hesitate to contact me at (208) 334-6626. Thank you for your participation in this process.

Sincerely,

Debby Ransom

DEBRA RANSOM, R.N., R.H.I.T
Chief
Bureau of Facility Standards

DR/mlw
Enclosures

IDAHO DEPARTMENT OF
HEALTH & WELFARE

DIRK KEMPTHORNE – Governor
KARL B. KURTZ – Director

Sue Broetje –Acting Administrative Director
IDAHO STATE SCHOOL AND HOSPITAL
Idaho Developmental Resource Center
1660 11TH Avenue North
Nampa, Idaho 83687-5000
PHONE 208-442-2812
Fax 208-467-0965
EMAIL broetjes@idhw.state.id.us

October 17, 2008

Debbie Ransom, R.N., R.H.I.T.
Bureau Chief
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83720-0036

RE: Idaho State School and Hospital, Provider #13G001

Dear Ms. Ransom:

Enclosed you will find the Plan of Correction for W125 and W149 and the applicable state referral tags which were cited on the amended survey report for August 12, 2008.

If you have any questions, please call me at 442-2812. Thank you.

Sincerely,

Susan Broetje
Administrative Director
Idaho State School & Hospital

lv

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 08/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This report incorporates changes resulting from the Informal Dispute Resolution (IDR) process. The following deficiencies were cited during the complaint survey. The surveyors conducting the survey were: Sherri Case, LSW, QMRP, Team Leader Matthew Hauser, QMRP Jim Troutfetter, QMRP Michael Case, LSW, QMRP Common abbreviations used in this report are: QMRP - Qualified Mental Retardation Professional	W 000		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure individuals' rights were protected and grievances and complaints were addressed for 1 of 1 individual (Individual #1) whose guardian filed a grievance. This resulted in a lack of a timely response to an individual's guardian's grievance. The findings include: 1. An on-site complaint investigation was conducted at the facility from 8/4/08 - 8/12/08.	W 125	see attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Program Director	10/7/8

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 08/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 125	Continued From page 1 During the entrance conference on 8/4/08 at 12:30 p.m., the survey team was provided all grievances filed at the facility since 5/1/08. A total of nine grievances had been filed, including a grievance filed by individual #1's guardian, dated 7/28/08. However, the 7/28/08 grievance filed by Individual #1's guardian contained no information regarding a response to the grievance. The facility's Client Complaint and Grievance policy, dated 4/22/08, defined "Complaint" as "A statement made by a client, legal guardian, or informal representative that indicates that they are in disagreement with a decision, policy, or procedure." The policy defined "Grievance" as "The formal process that occurs when the client, legal guardian, or personal advocate has been unable to satisfactorily resolve their complaint." The policy went on to state that "A complaint or grievance is not to be confused with an allegation of abuse or neglect." The grievance policy further stated that "Any allegations of client abuse, mistreatment, or neglect will be immediately forwarded to the Administrative Director for investigation per [Facility Name] Policy 01.11 regarding Abuse Prevention and ICF/MR Regulation Appendix Q." The procedures section of the policy stated the following was to occur: Complaint/Grievance Process: "Ideally, the client, guardian and/or representative will be encouraged, but not required to, make a good faith effort to try and solve the issue at the source, or lowest level appropriate for desired outcome. If the issue is not resolved, the client,	W 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 08/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 125	Continued From page 2 guardian, and/or representative may file a grievance." Phase I stated: - Step A: "As needed, staff will assist the client or their representative in the steps for filing the grievance, including completing the Client Complaint and Grievance,...Form #8378." - Step B: "The Client Complaint and Grievance form will be forwarded to the client's Social Worker for resolution. The Social Worker will assemble a Review Team (a minimum of 3 and a maximum of 5 members) that consists of one... and at least two Treatment Team members. This team will review the information and propose and discuss a resolution to the client within 5 working days. The resolution and client's degree of satisfaction with the resolution will be documented on the form (#8378)." - Step C: "A copy of the Client Complaint and Grievance form with the Review Team's resolution, Page 1, will be forwarded to the Social Worker for monitoring and follow up. The Social Worker will also contact the guardian, when applicable, to inform them of the grievance and the process for resolution." When asked why Individual #1's guardian's grievance had not been resolved, during an interview on 8/8/08 from 1:00 - 1:15 p.m., Individual #1's Social Worker stated the grievance forms had been removed from his possession on 8/4/08, by the facility's administration due to the survey and had not been returned or resolved. On 8/4/08, no evidence of resolution was documented for Individual #1's guardian's grievance, dated 7/28/08.	W 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 08/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 125	Continued From page 3 The facility failed to respond to Individual #1's guardian's grievance in a timely manner.	W 125		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on review of the facility's policies and procedures, record review, and staff interview it was determined the facility failed to adequately develop policies necessary to protect individuals from verbal abuse, psychological abuse, and exploitation by other individuals residing at the facility, which had the potential to impact 84 of 84 individuals residing at the facility. This resulted in the facility's inability to identify individuals who may be subjected to ongoing verbal abuse, psychological abuse, and exploitation by other individuals residing at facility. The findings include: 1. An on-site complaint investigation was conducted at the facility from 8/4/08 - 8/12/08. During that time the facility's abuse, neglect and mistreatment policies and procedures were reviewed and showed the following concerns: a. The facility's Abuse Prevention policy, dated 4/11/08, stated "This policy describes actions, inactions, and conditions that may be considered abuse or neglect by staff or other non-residents towards individuals who reside at [facility name]." Under the section titled "Definitions," the Abuse	W 149	see attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 08/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 4 Prevention policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The abuse section of the policy included psychological abuse, defined as humiliation, harassment, threat of punishment or deprivation of/to an individual. The policy listed examples of psychological abuse which included "Directing or permitting a client to injure another individual." Additionally, the Abuse Prevention policy defined neglect as the failure to provide goods and services necessary to avoid physical harm or mental anguish. The policy listed examples of neglect which included "Directing or permitting a client to humiliate, ridicule, threaten, intimidate or make fun of another individual" and "Directing or permitting a client to curse or use profane language or inappropriately scream or yell at another individual." Under the section titled "Procedures," the Abuse Prevention policy stated the Administrative Director or designee would determine if an allegation meets the definition of potential abuse or neglect and "ensure that sufficient action has been taken so clients are protected from the potential for further abuse or neglect until the investigation is complete." Although the policy addressed how "abuse or neglect by staff or other non-residents towards individuals who reside at [facility name]" would be addressed, the policy did not address allegations of abuse, neglect, or mistreatment towards an individual residing at the facility by a peer. b. The facility's Client Significant Event Reporting	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 08/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 5 policy, dated 1/4/08, stated "The purpose of this policy is to outline steps to document and address significant events that have either resulted in harm or pose a significant risk of harm to the clients who reside at [facility name]. The policy also provides a system for developing procedures to reduce these types of incidents as well as a system of aggressive team action and administrative review of significant events." Under the section titled "Definitions," the Client Significant Event Reporting policy defined a "Significant Injury" as a bodily injury which either requires medical treatment by a nurse, physician, or outside medical care provider, or bruising accompanied by severe pain, redness, swelling, or being warm to the touch. A subsection under "Significant Injury" included injuries "Caused by Assault From Another Client." Additionally, under the "Definitions" section the policy defined "Sexual Assault" and "Sexual Misconduct" as action between two individuals residing at the facility. However, the Client Significant Event Reporting policy did not address incidents of verbal abuse, psychological abuse, or exploitation of an individual by other individuals residing at facility. c. The facility's Client Minor Incident Reporting policy, dated 1/4/08, stated "The purpose of this policy is to outline a system for tracking minor injuries and incidents that may pose a risk to client safety. The policy also outlines procedures for addressing and reducing these potential risks." Under the section titled "Definitions," the Client	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 08/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 6 Minor Incident Reporting policy defined a "Minor Injury" as a cut, scratch, bruise, abrasion, or other minor physical trauma which can be addressed with no treatment or simple first aid, but did not require treatment by a nurse, physician, or outside medical provider. A subsection under "Minor Injury" included injuries "Caused by Assault from Other Client." However, the Client Minor Incident Reporting policy did not address incidents of verbal abuse, psychological abuse, or exploitation of an individual by other individuals residing at facility. d. The facility's Client Complaint and Grievance policy, dated 4/22/08, defined "Complaint" as "A statement made by a client, legal guardian, or informal representative that indicates that they are in disagreement with a decision, policy, or procedure." The policy defined "Grievance" as "The formal process that occurs when the client, legal guardian, or personal advocate has been unable to satisfactorily resolve their complaint." However, the Client Complaint and Grievance policy did not address incidents of verbal abuse, psychological abuse, or exploitation of an individual by other individuals residing at facility. Without a clear definition of verbal abuse, psychological abuse, or exploitation of an individual by other individuals residing at facility, and procedures to track such incidents, the facility would be unable to identify patterns of victimization, ensure the safety of those individuals being victimized, and investigate incidents of victimization. During an interview with the Administrator and the	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 08/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 7 Program Director on 8/8/08 from 2:00 - 3:05 p.m., when asked about the facility's system for tracking individuals who were victims of verbal abuse, the Administrator stated there was no system in place that would track individuals' victimization by other individuals for anything other than physical aggression. The Administrator stated the facility's QMRPs may have their own systems for tracking individuals' victimization by peers. On 8/11/08 from 12:15 - 12:20 p.m. the staff responsible for compiling all individuals' raw data was interviewed. When asked if the facility had any way of tracking individuals who were victims of verbal abuse, psychological abuse, or exploitation by peers from the data collected by the facility, the staff stated no current system was in place. On 8/11/08 between 11:55 a.m. - 1:30 p.m., six QMRPs were interviewed. When asked if there was any way to track individuals who were victims of verbal abuse, psychological abuse, or exploitation by peers, the QMRPs all stated there was not. Also on 8/11/08 between 11:55 a.m. - 1:30 p.m., three Clinicians were interviewed. When asked if there was any way to track individuals who were victims of verbal abuse, psychological abuse, or exploitation by peers, the Clinicians all stated there was not. The facility's policies and procedures did not address individuals' victimization by peers from verbal abuse, psychological abuse, or exploitation. Without systems in place to identify those individuals being victimized by peers, the	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 08/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 8 facility would be unable to protect individuals from further abuse, investigate incidents of abuse, and develop appropriate corrective action to prevent further abuse. The facility failed to ensure policies and procedures to address incidents of verbal abuse, psychological abuse, or exploitation of individuals by other individuals residing at facility were developed and implemented.	W 149		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 08/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM167	16.03.11.075.07 Exercise of Rights Exercise of Rights. Each resident admitted to the facility must be encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end can voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal. This Rule is not met as evidenced by: Refer to W125.	MM167	refer to attached for W125	
MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W149.	MM177	refer to attached for W149	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Program Director — (X6) DATE: 10/17/8

Plan of Correction for Amended 8/12/08 Complaint Survey

W125

1. Corrective action to be accomplished for those individuals found to have been affected by the deficient practice:

The grievance filed by Individual #1's guardian on 7/28/08 has been through Phase I (the team level) and Phase II (a Client Grievance Committee appointed by the Administrative Director) of our grievance process. Both solutions have been rejected by the guardian. This grievance is now in Phase III (Independent Review) and we are waiting for Individual #1's guardian to select a person or group to make this review. We have modified our policy and practice to ensure the timely response to individuals who reside here, their legal guardians, or personal representatives.

2. Method of identifying other individuals with the potential to be affected by the same deficient practice and what corrective action will be taken:

ISSH accepts that all the individuals who reside here, their legal guardians, or personal representatives could potentially be affected. See Item #3 for corrective action.

3. Measures to be put in place or systemic change to be made to ensure that the deficient practice does not recur:

ISSH will review and revise the current Client Complaint and Grievance policy to include a tracking form to ensure that timelines are met and there is improved accountability for each step of the process.

4. Monitoring system to ensure the deficient practice will not recur:

The Social Worker will track all phases of the complaint/grievance process and review with the team in the regularly scheduled team meetings. The QMRP will review all complaints or grievances in their monthly review and document any problems noted in the process.

5. Date by which corrective action will be completed:

10/17/08

W149 Plan of Correction

1. Corrective action to be accomplished for those individuals found to have been affected by the deficient practice:

The citation does not refer to a particular individual or individuals.

2. Method of identifying other individuals with the potential to be affected by the same deficient practice and what corrective action will be taken:

ISSH accepts that all the individuals who reside here could potentially be affected. See Item #3 for corrective action.

3. Measures to be put in place or systemic change to be made to ensure that the deficient practice does not recur:

ISSH will review all current policies related to the mistreatment, neglect, or abuse of a client. We will make changes to address incidents of verbal abuse, psychological abuse, or exploitation of individuals by other individuals residing at ISSH. ISSH will develop a system to track incidents of verbal abuse, psychological abuse, or exploitation of individuals residing at ISSH, including the perpetrator and victim.

4. Monitoring system to ensure the deficient practice will not recur:

ISSH will ensure that all incidents of verbal abuse, psychological abuse, or exploitation of individuals by other individuals residing at ISSH are reported immediately to the Administrative Director. The QMRP will review the above listed tracking sheet for both perpetrators and victims weekly, and make any needed interventions. The QMRP will also review all incidents of verbal abuse, psychological abuse, or exploitation of individuals by other individuals residing at ISSH in their monthly QMRP review. Our Performance Improvement Department will review this data quarterly and present findings to administrative staff including the Program Director. The Program Director will take needed action to ensure that clients are safe from verbal abuse, psychological abuse, or exploitation of individuals by other individuals residing at ISSH.

5. Date by which corrective action will be completed:

10/17/08